DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF10125 (01/03)

STATE OF WISCONSIN
WI Stats. s. 49.46

REQUEST FOR MEDICAID PRESUMPTIVE DISABILITY DECISION

Instructions: This form is to be completed by the county/tribal Economic Support (ES) worker.

This is a request for a Medicaid presumptive disability decision. This form must be completed and submitted with the following:

- ✓ Medicaid Disability Application form (HCF 10112)
- ✓ Confidential Information Release Authorization form (HFS-9)
- ✓ Any medical documentation immediately available that demonstrates disability or urgent need.

Certifying County / Agency Code	Name (Economic Support Worker)
County / Agency Telephone Number	County / Agency Fax Number

Applicant Name (Last, First, MI)

Applicant Social Security Number	Applicant's Telephone Number

There is an urgent need for medical services, because the above applicant (check all that apply):

☐ Is a patient in a hospital or other medical institution.

☐ Will be admitted to a hospital or other medical institution if immediate health care treatment, is not provided.

☐ Is in need of long-term care and the nursing home will not admit the applicant until Medicaid benefits are in effect.

☐ Is unable to return home from a nursing home unless in-home service or equipment is available and this cannot be obtained without Medicaid benefits.

Fax this form with additional information to:

Case File Management Unit
Disability Determination Bureau
Fax: (608) 266-8297